STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/22/11 Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Twin City Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000	SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION R AN AGREEMENT BY THE PROVIDER OF THE TRUTH OF FACTS ALLEGED OR CORRECTIONS SET FORTH ON THE STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAWS. PLEASE ACCEPT THIS PLAN OF CORRECTION AS OUR CREDIBLE ALLEGATION OF COMPLIANCE.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 75 and had a census of 55 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/25/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to	K0018	1A. ROOM 106 DOOR HAS BEEN REPAIRED AND NOW LATCHES PROPERLY. 1B. ALL	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure 1 of 12 resident room corridor doors on A hall closed and latched into the door frame. This deficient practice could affect any of the 17 residents on A hall. Findings include: Based on observation with the Maintenance Supervisor on 08/22/11 at 11:51 a.m., the corridor door to resident room 106 failed to latch into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 13 resident room doors on D wing protecting corridor openings. This deficient practice could affect a 18 residents on D wing. Findings include: Based on observation with the Maintenance Supervisor on 08/22/11 at 12:35 p.m., the		OTHER RESIDENT ROOM DOORS HAVE BEEN CHECKED TO ENSURE THEY LATCH. 1C. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 1D. ALL DOORS WILL BE CHECKED BY MAINTENANCE DURING ROUTINE FIRE DRILLS AND WHEN PREVENTATIVE MAINTENANCE IS COMPLETED. 1E. COMPLETION DATE SEPTEMBER 9, 2011 2A. ROOM 209 WAS IMMEDIATELY FIXED TO ENSURE DOOR WAS UNOBSTRUCTED. 2B. ALL OTHER RESIDENTS DOORS HAVE BEEN CHECKED TO ASSURE NO OBSTRUCTIONS IN PATH OF DOOR. 2C. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 2D. ALL DOORS WILL BE CHECKED BY MAINTENANCE DURING ROUTINE FIRE DRILLS AND WHEN PREVENTATIVE MAINTENANCE IS COMPLETED. 2E. COMPLETION DATE SEPTEMEBER 9, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	corridor door to resident room 209 was obstructed by a bed mattress placed on the floor beside the resident bed. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to	K0025	**K 025** 1. GAPS AT CEILING NEAR LAUNDRY VENTS	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of laundry staff. Findings include: Based on an observation with the Maintenance Supervisor on 08/22/11 at 11:57 a.m., there were gaps at the ceiling in the laundry room around each of the three dryer vents. The gaps ranged in size from one fourth inch to three fourths inch between the vent and the ceiling drywall. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)		WERE IMMEDIATELY REPAIRED 2. THERE WERE NO OTHER GAPS FOUND IN THE FACILITY. 3. NO SYSTEMATIC NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 4. ANY GAPS THAT REQUIRE REPAIR WILL BE REPAIRED IMMEDIATELY. 5. COMPLETION DATE SEPTEMBER 9, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0045 SS=E	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide continuous illumination for 4 of 6 exit discharges that could not be controlled by light switches. LSC Sections 7.8 requires continuous illumination during the time the conditions of occupancy require the means of egress be available for use. This deficient practice could affect any resident evacuated through A, B and C hall and the main dining room exits. Findings include: Based on observations with the Maintenance Supervisor on 08/22/11 from 11:25 a.m. to 12:50 p.m., the emergency exterior lights were controlled by a corridor light switch at the main dining room exit and the A, B and C hall exits. This was confirmed by the Maintenance Supervisor at the time of observations.	K0045	**K 045** 1. THE SWITCHES AT THE MAIN DINNING ROOM A, B, AND C HALL EXITS WERE CHANGED AND NO LONGER ARE CONTROLLED BY A CORRIDOR SWITCH. 2. THERE ARE NO OTHER EMERGENCY EXTERIOR LIGHTS CONTROLLED BY LIGHT SWITCHES. 3. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 4. THERE WERE NO OTHER SWITCHES IDENTIFIED AS A CONCERN. 5. COMPLETION DATE SEPTEMBER 9, 2011	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0046 SS=B	3.1-19(b) Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any occupant in C hall. Findings include:	K0046	**K 46** 1. THE BATTERY OPERATED LIGHT ON C HALL WAS REMOVED AS OTHER EMERGENCY LIGHTING IS AVAILABLE. 2. BATTERY OPERATED LIGHT WAS REMOVED 3. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 4. THE FACILITY HAS NO OTHER BATTERY OPERATED LIGHTS. 5. COMPLETION DATE SEPTEMBER 9, 2011	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on an observation with the Maintenance Supervisor on 08/22/11 at 11:00 a.m., a battery operated emergency light was observed in the corridor of C hall. Based on an interview with the Maintenance Supervisor at the time of observation, there were no written records of a monthly test or an annual test regarding the battery operated emergency light available for review. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted for staff was maintained and the metal container with a self closing cover was used for an ashtray. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Maintenance Supervisor on	K0066	**K 066** 1. THE CIGARETTE BUTTS WERE PICKED UP AND DISPOSED OF IMMEDIATELY. 2. THE RESIDENT SMOKING AREA WAS ASSESSED AND ALL SMOKE MATERIALS WERE DISPOSED OF IN NONCOMBUSTIBLE METAL CONTAINER. 3. SMOKE AREA WILL BE CHECKED DAILY BY HOUSEKEEPING WHEN CLEANING THE SMOKE AREA TO ASSURE CIGARETTE	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	08/22/11 at 12:40 p.m., the staff designated outside smoking area was provided with a noncombustible metal container used for cigarette butts, however, at least fifty cigarette butts were observed on the ground in the smoking area beside the metal container. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		BUTTS ARE DISPOSED OF PROPERLY. STAFF EDUCATED WITH REGARDS TO DISPOSING OF CIGARETTES PROPERLY. 4. THERE WERE NO OTHER AREAS AFFECTED. 5. COMPLETION DATE SEPTEMBER 9, 2011	
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure the complete range hood fire extinguishing system was UL 300 approved. Life Safety Code (LSC) 19.3.2.6 refers to LSC 9.2.3. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers shall be checked for	K0069	**K 069** 1. THE RANGE HOOD FIRE EXTINGUISHING SYSTEM IS NOT UL 300 APPROVED, SO ELWOOD FIRE PROTECTION HAS PROVIDED QUOTE TO UPGRADE SYSTEM. 2. THE RANGE HOOD FIRE SYSTEM WILL BE REPLACED BY SEPTEMBER 21, 2011. 3. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME.	09/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	proper operation during the inspection in accordance with the manufacturer's listed procedures. NFPA 96, 7-2.2 requires automatic fire extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could affect any resident in the main dining room in the event of an emergency. Findings include: Based on review of the Elwood Fire Equipment Co. Inc. range hood fire extinguishing equipment inspection report titled "Kitchen Fire Suppression Report" with the Maintenance Supervisor on 08/22/11 at 11:10 a.m., there was no documentation indicating the system was UL 300 approved. Based on an interview with with the Maintenance Supervisor after a phone call to Elwood Fire Equipment Co. Inc., it was confirmed the hood fire extinguishing system was not UL 300 approved. 3.1-19(b)		4. ELWOOD FIRE PROTECTION WILL INSTALL PARTS AND MAINTAIN SYSTEM ON ROUTINE MAINTENANCE CHECKS. THIS WAS ONLY AREA AFFECTED. 5. COMPLETION DATE SEPTEMBER 21, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 08/22/11 at 12:45 p.m., there was a rolling fire door protecting	K0130	**K 130** 1. THE ROLLING FIRE DOOR PROTECTING THE KITCHEN TO MAIN DINING ROOM WILL BE INSPECTED BY ELWOOD FIRE PROTECTION BY SEPTEMBER 21, 2011. 2. THERE WERE NO OTHER AREAS AFFECTED WITH REGRADS TO FIRE INSPECTION BEING OUT OF COMPLIANCE. 3. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 4. ALL OTHER ANNUAL INSPECTION OF FIRE DOORS WERE CURRENT. 5. COMPLETION DATE SEPTEMBER 21, 2011	09/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the opening from the kitchen to the main dining room. The rolling fire door was not in a corridor wall but was in a fire wall. Based on interview with the Maintenance Supervisor at the time of observation, there was no documentation of an annual inspection or test to check for proper operation. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room	K0144	**K 144** 1A. THE EMERGENCY GENERATOR WILL HAVE A REMOTE MANUAL STOP ADDED BY SEPTEMBER 21, 2011. 1B. THERE WERE NO OTHER AREAS AFFECTED. 1C. NO SYSTEMATIC CHANGES WILL BE MADE AT THIS TIME. 1D. THE ELECTRICIAN WILL COMPLETE THE PLACEMENT OF THE REMOTE MANUAL STOP BY SEPTEMBER 21, 2011 AND NO	09/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 08/22/11 during a tour of the facility from 11:10 a.m. to 1:45 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Supervisor at 10:35 a.m., the generator had a motor rated over 100 horsepower. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care		OTHER AREAS WERE AFFECTED. 1E. COMPLETION DATE SEPTEMBER 21, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. NFPA 101, Section 4.6.12.1 requires any device, equipment or system required for compliance with the provisions of the Code shall be continuously maintained in accordance with applicable NFPA requirements. NFPA 72, National Fire Alarm Code, in 7-4.3 requires all apparatus requiring resetting to maintain normal operations shall be reset as promptly as possible after each test and alarm. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 08/22/11 at 12:55 p.m., the audible alarm switch was turned to the off position on the generator annunciator panel located at the nurses' station. The light indicating an "anticipatory low oil pressure" trouble was illuminated. Based on an interview with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Supervisor at the time of observation, he stated he was not made aware of the trouble alarm. 3.1-19(b) 3. Based on record review and interview, the facility failed to provide the complete documentation for the weekly visual inspection of 1 of 1 emergency generators providing power to the emergency systems. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants. Findings include:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155232	A. BUILDING 01 B. WING	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 EAST NORTH H ST GAS CITY, IN46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on a review of the generator log "Generator Log Sheet" with the Maintenance Supervisor on 08/22/11 at 10:45 a.m., the weekly inspection included only the individual hours and the weekly start and weekly stop times. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review. 3.1-19(b)			